

THC MEDISPA & CLINIC

PERIODIC WELL WOMEN'S HEALTH ASSESSMENT

Please fill out this questionnaire as completely as possible. The information provided will become part of your medical record and is totally confidential. This information will assist us in our effort to provide quality health care.

Name: _____ Preferred Name: _____
(Last) (First) (Middle Initial)

Today's Date: _____ DOB: _____ Marital Status: _____ Occupation: _____

What would you like to address in today's visit? _____

LIFESTYLE/RISK ASSESSMENT:
SMOKING, ALCOHOL, DRUGS, ABUSE

Do you currently smoke cigarettes? no, never have exposure to second hand smoke

yes Date Started: _____ Amt/PPD: _____ quit Date Stopped: _____

How many alcoholic drinks do you have in an average week? none # _____

Do you ever drink more than 3 at one sitting? no yes _____

What recreational drugs are you currently using? none marijuana heroin crack cocaine painkillers other _____

Have you been physically or emotionally abused? no yes

EXERCISE & DIET

Do you exercise and if so, how often? regularly occasionally rarely never

What type of exercise: _____

Do you have any concerns about your weight? none gain loss

Do you have any concerns about what you eat: no yes

How many different types of fruits and vegetables do you have in your house right now: 0-3 _____ 4-8 _____ 9 or more _____

SEXUAL HISTORY

Have you ever had sex or been sexually active? no yes If yes, are you currently having sex? no yes

Do your partner(s) have a penis vagina (check all that apply)

Have you or your partner(s) had new sexual partners since your last STD/STI test? no yes

Do you have concerns about sexually transmitted infections? no yes unsure

Do you have any concerns about sex or your sexual health? no yes

Do you have any concerns about vaginal dryness or pain with intercourse? no yes

Do you have any concerns about libido? no yes

Are you planning a pregnancy ? now in future never unsure

If at risk for unplanned pregnancy, what method of birth control are you using? _____

ALLERGIES:

Please note any allergies/ reactions to medications or other agents. None

Allergen and reaction:

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: None If you would like a list of current medications in your HVMA record, please ask Medical Assistant to provide.

Med/Dose/Instr: _____

Med/Dose/Instr: _____

Med/Dose/Instr: _____

IMMUNIZATIONS:

Have you obtained a Tdap immunization (tetanus, diphtheria, pertussis)? no yes don't know
Have you been vaccinated against the HPV virus? no yes don't know
Have you had a flu shot this year ? no yes don't know

MENSTRUAL STATUS:

If pre-menopausal: Date of your last Menstrual Period: _____ Do you have any concerns about your menstrual cycle: _____ Are your periods currently: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Is your Flow: <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy How often do you have periods: _____ How many days do your periods last? _____ Do you have spotting or bleeding between periods? <input type="checkbox"/> no <input type="checkbox"/> yes Do you have menstrual pain/cramping? <input type="checkbox"/> no <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe What medications do you take for this? _____	If post-menopausal: Are you experiencing any vaginal bleeding? <input type="checkbox"/> no <input type="checkbox"/> yes Did you use hormones? <input type="checkbox"/> no <input type="checkbox"/> yes If yes: Oral/Patch <input type="checkbox"/> current <input type="checkbox"/> past Vaginal <input type="checkbox"/> current <input type="checkbox"/> past
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GYNECOLOGIC HISTORY Check if you have had any of the following:

- Abnormal Pap Test
- DES Exposure in Utero (when your mother was pregnant with you)
- Pain with sex (dyspareunia)
- Endometriosis or Adenomyosis
- Fibroids, uterine
- Infertility
- Ovarian Cyst, type: _____
- Chronic Pelvic Pain
- Pelvic Inflammatory Disease
- PMS
- STI/Sexually Transmitted Infections
- Chlamydia
- Genital Herpes
- Gonorrhoea
- Genital Warts
- Hepatitis B
- Hepatitis C
- HIV/AIDs
- Syphilis

None

- Abnormal Uterine Structure (Uterine Anomaly)
- Urinary Incontinence
- Vaginal dysplasia (precancer)
- Vulvar dysplasia (precancer)
- Vulvar Pain/Vulvodinia
- Recurrent Vaginitis
- Yeast
- BV
- Other _____

MEDICAL /SURGICAL HISTORY:

Since your last exam here, have you had any major health problems or surgery? no yes, explain:

FAMILY HISTORY: Please note any changes in the health of your family since your last visit: None

REVIEW OF SYSTEMS: Check if you *currently* have *problems* with:

- fatigue
- weight loss
- weight gain
- easy bruising
- enlarged glands or lumps
- environmental allergies
- hot flashes
- heat or cold intolerance
- excess hair growth
- excessive hair loss
- skin
- moles
- chest pain
- persistent cough
- shortness of breath
- wheezing
- difficulty breathing
- indigestion or nausea
- abdominal pain
- abdominal bloating
- constipation
- diarrhea
- painful urination
- involuntary loss of urine
- abnormal vaginal discharge
- headaches
- fainting/dizziness/balance
- anxiety
- depression
- memory loss
- trouble sleeping
- varicose veins
- muscle or joint pain
- back pain
- breast pain
- breast discharge
- breast lump
- Other _____

Please note any other stresses or anything else you think we should know:

If your Primary Care Physician (PCP) is not an Atrius physician please tell us:

PCP Name, Address: _____

Check box if you would like us to send a copy of your visit note to your PCP

Signature: _____ Date: _____